COLORADO HIGHER EDUCATION
INSURANCE BENEFITS ALLIANCE
CHEIBA TRUST MEETING

A. MEETING LOCATION AND DATE:

CSU Pueblo
Occhiato University Center, Aspen Leaf Room 212
Pueblo, CO 81001

March 24th, 2016, Meeting began at 10:00 a.m.
March 25th, 2016, Meeting began at 8:00 a.m.

B. GENERAL BUSINESS:

1. Call to order

   The meeting was called to order by Mike Dougherty, Chair. The following individuals were in attendance:

   - Tracy Rogers, Adams State University
   - Blaine Nickeson, Auraria Higher Education Center
   - Ralph Jacobs, CSU Pueblo
   - Susan Benesch, CSU Pueblo
   - Luc Cisna, CSU Global
   - Darren Mathews, Fort Lewis College
   - Ann Hix, Colorado School of Mines
   - Mike Dougherty, Colorado School of Mines
   - Veronica Graves, Colorado School of Mines
   - Amanda Berry, Metropolitan State University of Denver
   - Marshall Parks, University of Northern Colorado
   - Kim Gailey, Western State Colorado University
   - Michele Moreau, Gallagher
   - Neida DeQuesada, Gallagher
   - Margo Reid, Gallagher
   - Tracy Paladino, Gallagher
   - Janet Pogar, Anthem
   - Paula Wilson, Anthem

   The following individuals participated at various times via conference call:

   - Pepper Krach, Gallagher
   - Kathleen Schultz, Gallagher
   - Annmarie Manders, Anthem
   - Jim Thorne, Anthem
   - Mike Beaton, Anthem
   - Desiree Delgado, Anthem
   - Dixon Waxter, Trust Attorney
   - Shannon Heersink, Adams State

2. Approval of January Business Session Minutes
Motion was made to approve the January minutes. The motion was seconded and approved (unanimous).

3. Approval of March Agenda
Motion was made to approve the March agenda. The motion was seconded and approved (unanimous).

C. PUBLIC COMMENT: - 9:15 a.m., March 24, 2016

While meeting was not in session until 10 a.m. due to a weather delay, alternate trustee from CSU Pueblo was in the meeting room at 9:15 a.m., and no one appeared for public comment.

D. REPORTS:

1. CHEIBA Trust Reports – Medical, Dental, Vision and Life

The timing of the reports continues to be a challenge. Anthem's system generates reports generally around the 21st of each month for all clients. The timing of Anthem's reporting to Gallagher affects whether Gallagher has sufficient time to review and produce a final reporting package to share with Trustees at the meeting. Without adequate time to prepare, Gallagher cannot guarantee that the last month's data will be included in the reporting package presented at the meeting.

- The reports included data for the month of January only
  - The January numbers are estimates because Gallagher is still working with Anthem on PEPM, retention and ACA fees, primarily for the dental and vision programs. The medical retention and ACA fees appear correct. Next report will reflect accurate numbers.
  - Data for employees enrolled into new HMO and HSA plans are not included in January but will be included moving forward
  - $2.8M in medical paid claims vs. $3.3M last January
  - Total medical/Rx $3.2M vs. $3.9M last January
  - Medical premium up about $200,000
  - More employees enrolled in January 2016 than 2015 -- 3,833 vs 3,752, up 2.2%. We may yet see further adjustments in enrollment due to new plans being added.
  - Approximately 74.6% paid loss ratio without PPACA vs. 97.9 % last January
  - Approximately 83.4% paid loss ratio with retention or PPACA vs. 107% last January
  - Current year to date net medical paid claims vs. prior year to date claims in January are down 9.2%

- HMO/POS Plan
  - $2.4M in med claims vs $2.5M last January
  - Rx was lower last year, up slightly in January 2016
  - Combined medical/Rx in January was $2.7M vs. $2.9M last January
  - January enrollment increased 5% from last January with 2,848 employees vs. 2,710, up 3% from 2015 end of year
  - Average paid claim PEPM $953.84 vs $914.21 end of 2015 year
  - Paid loss ratio is approximately 85.6% without PPACA vs. 102.1% last January

- Paid loss ratio with retention and without PPACA approximately 94.5% vs. 111.2% last January
- Current year to date net medical paid claims vs. prior year to date claims in January are down 7.7%

- PPO Plan
  - PPO running well; enrollment is down
  - $340,887 in medical claims vs $757,833 last January
  - Rx decreased by 46.6% from January 2015
  - Combined medical/Rx in January was $441,980 vs. $963,654 last January
  - January enrollment decreased by 5.6% from last January with 961 employees vs. 1,015
  - Paid loss ratio is approximately 39.6% without PPACA vs. 86.5% last January
  - Paid loss ratio with retention and without PPACA approximately 48.1% vs. 95.3% last January
  - Current year to date net medical paid claims vs. prior year to date claims in January are down 50%

- Custom Plus Plan
  - Reminder that this is a Grandfathered plan with no new enrollment – 24 employees currently enrolled vs. 27 last January
  - $61K in claims vs $36K last January

- Dental Plan
  - January 2016 reflects approximately $224K in paid claims. This is down slightly from $227K in January of 2015.
  - Total premium up slightly
  - January enrollment decreased 2.2% from last January with 3,703 employees vs. 3,784
  - Michele confirmed that dental should be automatically included when medical elected.
  - Year to date claims are up 3.4% from the previous January, with 2015 renewal trend of 6%
  - Mike D. asked about the retention. Michele agreed that it does not look right and will investigate and present at next meeting.

- Vision Plan
  - The data does not appear correct. Gallagher will work with Anthem to create accurate data to report at the next meeting of the Trust.

- Life Plan
  - There were no claims for January 2016
  - Retention for Life/AD&D is incorrect on the report showing 13.03% but should show as 10%; will be corrected on the next set of reports
  - Premium paid $128,745

- Large Claim Information reported by Paula from Anthem
  - 3 Large claims over $75,000 for the month of January
    - Premature Baby, $154,637 – baby is home and most claims were paid in January
    - HepC, $87,078 – requires regular medication infusions and physician follow up
    - Cardiac, $78,829

E. OLD BUSINESS:

1. GBS Update
   - Strategic Planning Discussion – Tabled for May meeting
     - Grandfather Status
     - Self-Funding

2. D & O Insurance Update – Thursday at 10 a.m.
   Tracy Paladino, Gallagher Risk Management
   Gallagher's Risk Management division was engaged to work with CHEIBA to provide quotes for Crime and Fiduciary coverage. Gallagher approached Travelers, Hiscox, and AIG for quotes on these lines. Both Hiscox and AIG declined to provide quotes as the Trust falls outside their underwriting appetites/guidelines. Travelers provided the following quotes. Tracy explained that they do handle the bulk of Gallagher's book of business.

   Crime:
   - Option 1: Limit of $1,000,000 with a $10,000 Self Insured Retention (SIR). The annual premium is $2,000. The prepaid three year policy term premium would be $5,699.
   - Option 2: Limit of $2,000,000 with a $20,000 SIR. The annual premium is $2,750. The prepaid three policy term premium would be $7,838.

   Gallagher's request for a $3,000,000 limit was declined by Travelers as they felt the Trust was too small to warrant this level of coverage at this time.

   Fiduciary:
   - Option 1: Limit of $1,000,000 with a $10,000 SIR. The annual premium is $10,800.
   - Option 2: Limit of $2,000,000 with a $25,000 SIR. The annual premium is $14,700.
   - Option 3: Limit of $3,000,000 with a $25,000 SIR. The annual premium is $18,900.

   Travelers does not offer a 3 year guarantee as they evaluate fiduciary coverage annually.

   Gallagher recommended the following:
   - Crime - $2,000,000 limit and three year policy term
   - Fiduciary - $3,000,000 limit option

   The proposal was provided to the Trustees prior to the meeting.

   Dixon sent an email to Tracy with questions prior to the meeting, and she responded via email. A couple of questions were discussed with the group. He did not see the definition of Employee in the sample crime policy. Mike noted that it appeared on page 8, and Tracy confirmed that her email response included a link to the definition. She also clarified who has access to funds. May have to provide additional endorsement to add agents of the Trust to allow access.

   Concern was raised about Travelers being the only one to provide a quote. The vendors who declined did so because the Trust is set up as a multi-entity arrangement. Blaine asked if Gallagher believed that the quotes were competitively priced. Tracy P. said yes and that the Crime came in lower than they expected to see. Michele asked if the risk for higher ed is different than the norm. Tracy confirmed that the risk is actually lower as Crime policies are

typically not an issue in higher ed space. The risk for computer fraud, cyber deception, social engineering, mistakenly transfers money based on email from others outside of organization, etc., is lower than the norm.

Fiduciary coverage pricing is in line with what Gallagher normally sees and is slightly lower than many higher ed plans because the health carrier is more involved in administering plan, limiting the exposure compared to other governmental plans.

One of the Trustees asked Dixon how the coverage interacts with the Governmental Immunity Act. Dixon commented that the Trust generally has immunity in tort and has Risk Management coverage but with some limitations. Currently, four of the Trust entities are covered by Risk Management, and Dixon is unsure of how Risk Management would approach it if a claim were to arise. Dixon had been negotiating a pro-rata coverage with Risk Management. As with the Mesa case, the Trust has immunity from tort. There is no agreement in writing as to how the coverage through Risk Management would work, however. Dixon would like a policy in place to protect in case of suit, limiting financial liability. Michele pointed out that this is inexpensive coverage considering the risk because of the increasing amount of litigation in general in this area of law. Michele reviewed Gallagher's recommendations and expressed that she's comfortable with Travelers as they are a respected provider.

Mike D. walked through his questions regarding the proposal (see below), in addition to other comments from Trustees.

- Reference is made throughout the proposal to the declarations. Where can these be found? Tracy P. explained that the declarations will be issued once the policy is actually issued. Michele referenced the process as being similar to producing a Summary Plan Description after the medical policy is issued. The Coverage Summary beginning on page 6 of the proposal shows what is covered, as proposed, if the option is selected. Mike D's concern was that the Trustees were being asked to review and accept a proposal without having knowledge of the content of the declarations.
- Page 10 – F, claim reporting instructions, referred to item 4 of the Declarations – what is this? Tracy confirmed will be Traveler's address.
- Mike D. also expressed concern that everything seems excluded. Significant discussion occurred in detail about the contents of the proposal and terms that were not familiar to the Trustees. Tracy P. answered the questions and provided explanations as items were raised by the Trustees.
- Using terms that are not defined. For example, what is the Discovery Form listed on page 6 of the Coverage Summary under "Terms and Conditions"? Difference between when the loss can be reported to the policy as of time loss is discovered, not actually date of loss.
- Removal of Short Rate Cancellation (page 6 of the Coverage Summary) – deals with how they would charge if coverage was terminated mid-term. By removing this term, the Trust can cancel policy without charging mid-term.
- Individual bonding exclusion – we don't exclude different positions from the bonding
- Excluded: Governmental Actions – Per Tracy P., if a government body makes some kind of change, e.g., new ruling, audit, etc., it would be excluded from coverage.
- Define retention/self-insured retention. Tracy explained it is the out-of-pocket cost, e.g. deductible.
- Fiduciary liability - $3M – Mike asked if this was low. Tracy said common amounts are $1-$2M and is suggesting $3M.

- Defense limits erodes deductible: if $25K retention, as expense costs build, you would not have to meet more, just goes toward deductible.
- Defense of benefits – will defend if employees sue based on benefits.
- Kim asked if policy would cover Breach of Contract – Tracy confirmed not normally, but the carrier would look at each individual situation specifically
- Confirmed would not subrogate against Anthem.
- Policy References (Extended Reporting Period – page 9 of Coverage Summary): Provision only applies when coverage is cancelling or will be moving to another carrier who will not honor the retroactive date. There is an opportunity for the Trust to purchase an additional amount of time in which to report claims that occurred during the time the policy was in force. It does not extend the limit of liability during the reporting period.
- Because fiduciary liability is claims paid, new carrier would need to match coverage date. Can buy time to report claims incurred during coverage period.
- Extended reporting – not included normally, but can buy at time of termination.
- Question about the definition of Benefit Plan Official (F.) – Tracy P. pointed out this is defined on page 2 of 15 under Fiduciary coverage,
- Page 15 of Coverage Summary, proposed insurance companies, A.M. Best's Rating of A++ XV – the XV refers to the Finance Size Categories table -- $2M or more (rating categories)
- Page 12 of 41 – Computer Virus – directed **solely** against the insured. What if a virus is directed against multiple Trust universities? Tracy P. said this would not be applicable since information is not residing on a common computer system owned by the Trust.
- The Trust keeps surplus funds at Anthem; what happens if cyber hack takes the funds. Tracy confirmed that Anthem would be responsible since the funds are in their systems.
- Blaine noted that he works with Karen at Gallagher for Cyber and Crime coverage for his University (among other coverages).
- Computer Virus discussion continued focusing on the term "natural persons" – This means that such instructions were maliciously introduced by a natural person. Tracy to confirm definition of natural person.
- Kim clarified that it appears that the insurance would only protect computer systems owned by the trust, and they don't own any. Extended to vendors as well as universities.
- Ralph – if information is sitting in a cloud repository, how would protection work? Tracy P. -- If contracting with cloud service, the vendor would have the protection. If the cloud service is open or public, there would not be protection.
- Page 30 of 41- replacing declarations page – Tracy confirmed it is showing $1M for base of specimen, but will be adjusted based on option you choose to buy.
- Social Engineering fraud – phishing scams. Example given, what if someone phishes on the computer of Blaine? Tracy said there is limited coverage in the policy depending on details.
- Page 1 of 33 on the Specimen – Quote 1 – As part of the Fiduciary Liability policy, the Trust will have up to one hour of consultation from the law firm of Morgan Lewis if a claims scenario or claims issue comes up that they would like to discuss prior to formally reporting a claim. There are also a variety of online resources available for the Trustees through Travelers.
- Page 14 of 33 in the Specimen Quote 1 – fiduciary, what is considered willful - statute that says cannot provide benefits in a certain way and you decide to ignore. Mike said what about ACA, okay as long as acting on good faith. Would investigate at time of claim.
- Michele – how often do they pay out after investigation? What about all of the exclusions? Tracy said you buy coverage for defense. Don't want to have to pay for defending. Tracy to

get back after talking with carrier about examples of when covered and exclusions. Travelers UW can hold meeting and discuss in more detail.

- Page 23 of 33, under Representations – if any statement is untrue it voids policy. Some of the application questions did not apply or were vague as to how to construe what was being asked. Mike D. raised a concern about how this section would apply. Tracy said would have to be question that did apply and you answered it incorrectly intentionally, would void.
- Page 25 of 33 – Insurance representative – Mike D. asked if back up could be listed in case of vacations, etc. Yes, per Tracy P. Mike replied that it should list Tracy Rogers, Vice Chair of the Trust.
- Page 26 – Document refers to a Benefit Plan Schedule but does not include one – Tracy P. said will be defined as soon as bound.
- Page 5 of Proposal "Conditions to Bind Coverage" –
  - Details on check issuance procedures – Blaine believes provided answers at time of application.
  - Fiduciary – confirm total participants – Gallagher can provide the number of participants on benefit plans
  - Resumes of Trustees – Travelers will need when they bind.
  - ACA compliance – Michele confirmed to best of her knowledge that, "yes," the Trust is in compliance with ACA.
  - CHEIBA must notify Gallagher of any changes in Trustees at time of renewal.
  - The Trust must notify Gallagher of any potential claims and Gallagher will help with notifying Travelers.
  - Dixon expressed a concern with an Employee question on Crime. Would like endorsement that covers agents. Gallagher and Anthem should be added. Tracy confirmed all agents will be scheduled.
  - Page 14 of 41 – Mike confirmed that #5 shows that attorneys are covered.

Mike asked the Trustees if they feel they can make a decision without seeing declarations page. Kim said yes.

Motion was made by Blaine to accept the Gallagher recommendation of $2M limit on the Crime policy and $3M limit on the Fiduciary policy. The motion was seconded by Tracy R. A friendly amendment was offered and accepted to add the three year pre-paid option to the Crime policy in the amount of $7,838. The motion was unanimously approved. No representative from CSU Global was present.

Blaine said discussion in July will be necessary on funding. Could pull some of the LTD claim deposit to offset. Michele said can do, but would have to be prepared to pay if claims come up.

Motion was made by Mike to make coverage effective April 1. The motion was seconded by Blaine and approved (unanimous).

Every trustee must provide resumes to Michele by March 31st. Final page before appendix will need to be signed by Mike. Check will be required after binding, following production of invoice by Gallagher.

3. Communication Presentation and Discussion – Friday 10 a.m.

Presentation "Engagement Leads to Effective Communication" presented by Pepper Krach, Communication Practice Leader and Kathleen Schultz, Wellbeing and Engagement Practice Leader from Gallagher.

Discussion began reviewing common challenges faced by HR and how "Wellbeing" has evolved. Kathleen discussed the importance of the wellbeing component in a successful communication campaign.

The majority of time was spent on the Communication Strategy section, discussion led by Pepper.

Current challenges faced by CHEIBA Trust:

- Participants are not reading communication materials – estimate that 80% don't read
- No communication strategy
- Targeting the proper audience – demographic study
- Maximize current resources – leveraging the resources available, i.e., Anthem
- Underutilized distribution channels – leverage website launched for employees

Discussed the importance of beginning with a Workforce Evaluation & Demographic Analysis.

- Consideration must be given to reaching Boomers (age 51-69), Gen-Xers (age 36-50) and Millennials (< age 35). Their interests and needs are very different, as well as comfort level with technology. The Trustees were agreeable to taking this step.
- Use a variety of measurements to track results
- Reviewed Workforce Evaluation results from another higher ed institution.
    - Easily see gender distribution, average age, average tenue, number of key employees and average compensation. This information is sliced and diced in different ways.
    - "Current State" exhibit blended the demographic information with the medical plan elections. This example showed that the majority of the retirees elected the PPO plan. A HDHP/HSA option was offered as well. This highlighted an educational opportunity to educate retirees on the advantages of enrolling in a HDHP/HSA program at a later stage in life, i.e., tax savings, savings and investment opportunities, etc.

For voluntary benefits, Gallagher created six page trifold and eight page booklets for voluntary benefits - mailed directly to homes. Compared enrollment with three groups with different communication campaigns. Mini booklets are excellent way to communicate specific messages to members.

CHEIBA currently has a website available with two sides, one for the Trustees and another for employees. The Trustees feel it is not being used often by employees, but it may be able to be expanded and used for communication. Blaine believes it is currently being used as a repository.

Pepper and Michele discussed a number of Distribution Channels, many with links (on page 31 of the presentation). If the Trustees decide to engage in the project, this site could be leveraged to share this information as well as tools and resources available through Anthem.

Pepper referenced a project with a Property & Casualty client – Mypath.org was put together by Griffith and CPU org. It was designed to help recruit and retain millennials to organization. It's very current with fun energy. Possible thought for a microsite. Currently doing many for large businesses. Again, discussed using the current site and building off of it.

Branding – know Trust is not interested in branding, but brand does have advantage of creating emotional connection. Reviewed MyPenske brand with fresh look to build better connection. Shared look and feel of trifold.

Paula said that when they worked on push campaign last summer, used My Health My Way.

Michele discussed price ranges and next steps for engaging Gallagher. Les is working on offering the Workforce Evaluation at no cost. Pepper provided estimate of around $15K for Stage 1 – putting a communication plan in place. This would include Pepper's expertise. Future cost is dependent on the strategy and where the Trust would like to take it, i.e. print, videos, etc. The approach for each institution could be different.

Mike asked for feedback of committee members on a more formalized communication strategy.

- Luc likes the idea, believes this is an area of opportunity. He thinks it will help employees as customers as well as help benefits administrators.
- Blaine agrees, believes the trustees can use assistance in this area.
- Tracy thinks it would be useful.
- Darren struggles with makeup being different at each campus. He suggested using the website in place. He thinks for his university, it would be a challenge sending employees to an outside site. Darren thinks his employees understand the brand of CHEIBA.

Paula shared that Anthem created microsite for another large university containing a lot of information. Could explore that. Darren asked what this might do to help control costs. Kim is struggling on the cost benefit, and if they can afford to do this. How do we get employees to relate the information to their situations? Need consideration of how we can help employees understand what or which of the plans are best for them.

Michele walked through examples of tools that help with enrollment, selecting plans, etc. Redirection to appropriate plans may significantly impact the plan performance. Ann feels they may overwhelm employees.

A decision tool is something the Trustees are very interested in. Anthem used a decision making tool for CSU with success. Luc asked if you could see how many hits are on the web page. Feedback is not as "fun" as something like Jelly Vision. How complex would it be to put in something like Jelly Vision? Ralph believes it is valuable to look at this. Mike requested to have detailed discussion on Jelly Vision in May.

Michele is currently looking at the Web Benefits system vendor who may be able to add enrollment tools and or decision making tools. Mike wants to create and know satisfaction with plans, but need employees to understand them. If we start working on it now, may have something available for 2017 open enrollment.

Mike asked if the Trustees would like to engage Gallagher for the first step. Gallagher will conduct the Workforce Evaluation. Michele mentioned that a census file will be shared shortly with Trustees containing many fields; the cover letter will show core elements and what is optional. Blaine would like to be sure data would be useful. Would like most meaningful data to come out of this analysis. Gallagher will share core and suggested elements and trustees and come to consensus. Add to May agenda to discuss further with Pepper's team.

4. FSA Update

   Blaine expressed concerns about the timing of the processing of his claim. His FSA account was updated on Feb. 4; however, his reimbursement was not credited to his personal bank account until Feb. 10th.

   24HourFlex confirmed that they update participant accounts on the day they receive the file upload from the institutions, barring there are no errors or questions with the file. Reviewed schedule of when files were sent:

   - CSU Global – Mar. 2
   - Auraria – Mar. 4
   - Western State – Mar. 1

   Discussed issue that School of Mines experienced previously with file upload and timeliness of response from 24HourFlex. Gallagher addressed with 24HourFlex. Jonathan advised that in case of an urgent matter, to opt out of his voicemail to be connected with another representative that can provide immediate assistance. The Trustees are also welcome to contact Gallagher (Neida) for assistance.

   Neida reminded the Trustees of email sent out regarding who on each campus had access to invoices as well as the 24HourFlex online portal.

   Kim and Ann both said they had members who submitted claims in December to PayFlex and PayFlex is saying they have no record of the claims. Neida will work with the institutions to resolve.

5. Standard LTD Update

   Michele explained that as of December 2015 there is $136,412 in the claims reimbursement deposit account. The contract allows for filing of claims within 90-days of the end of the Benefit Waiting Period, then allows for claims to be filed not later than 12 months after that 90 day period. The run-out period would be approximately 1.5 years out or April 2017. Gallagher has not been advised of any pending claims. Blaine's use of the CFR as a source of income assumed $80K would be left in the deposit account. He said they can reduce the $136,412 to $80K to $100K and use remainder for a source of additional income. Blaine would prefer to remove all except $80K. Michele to confirm if $80K was actual number in premium referenced in the minutes when considering going fully insured. There is possibility that someone can file a claim that was incurred during the self-funded plan period.

6. Benefits Administration System

   Ann mentioned in the January meeting that interest was expressed in the past (not recent) in looking at an online enrollment system to use throughout the Trust. Mike commented that it would have to accommodate all of the different institution premium structures. Trustees

discussed whether anyone uses online systems. Luc said that CSU Global uses UltiPro currently. Mike commented that all institutions likely have different security protocols and processes in place. Blaine said they are in the process of implementing a new system and commented it is extremely expensive. Luc thought that a system could provide a return on investment. The hours spent up front in system design and implementation pays off with return of time for the HR team to focus on other things. An online enrollment system also puts more responsibility on the member, which is positive. A benefits administration system could also include enrollment communication tools. Paula mentioned an online tool that Anthem is using for some clients called Plan Source. Special pricing is in place through Anthem if the Trust is interested. Darren mentioned they hired an I.T. resource to build a feed from Banner to Anthem, and it was not successful but expensive. There was general agreement among the Trustees that a benefits administration system is interesting, but not a high priority at this point. Michele said the process would include interviewing vendors, working with I.T., etc. Ann asked if anyone would be interested in just a web-based system that is synced with Anthem, but not tied to payroll. Luc commented that it would help with enrollment, but it is not ideal since systems wouldn't speak to each other. This item was tabled for further discussion in May.

7. Freestanding ER vs. Urgent Care Update -
   Mike D., Michele and Rebecca Weiss met at the State Capitol March 4 on Freestanding ER draft bill. In its current state, it is not applicable to freestanding ERs owned by hospitals. Anthem is attempting to have this changed. As discussed earlier, the bill's primary purpose is to provide transparency of services and pricing of freestanding ERs.

8. Anthem Update

   - Vision
     - Premium Tiering - Added 6 new suffix codes. Logic added to tie families together so billed correctly. January – March bills were sent out this week. No major problems or questions.
     - Contracting Update
       - 34 total providers. 18 declined to join. 11 no response. 5 agreed to join (1 in processes of credentialing).
       - A few of the Trustees commented that their personal eye doctors indicated that they were not interested in joining the network. Darren commented that the Durango area eye doctors said Anthem is slow to pay. It was noted that since they are not in the network, the statement may not be accurate.
       - Tracy's provider was actually in network, but was not providing accurate information to patients.
     - Performance Guarantee - $5,000 was at risk. Brought in 4 out of initial list of 34, therefore met guarantee.

   - Medical Integration

     Anthem Whole Health Connection is a program that enhances clinical care with more data including dental, vision, disability and pharmacy, and increases a bigger picture of patient health. A provider billing newsletter (draft included in packet) explains the benefits of this program will be sent to providers in early April. This letter includes instruction for accessing a tutorial document for the Member Medical History Plus (MMH+) personal health record. Provider workshops held bi-annually will include training on the MMH+ record as well. Whole Health Connection is for all coverages covered under Anthem. Providers can

log in to retrieve information about patients prior to or after their office visits. Janet said 80% of doctors have access to the portal, which includes access to the MMH+ records. Anthem is converting to this with all models. AnnMarie asked if Anthem has done a push with dental providers to get more info to them on the Whole Health Connection. Anthem will research and advise.

- Open Enrollment Update
  - Numbers by plan
  - Numbers by tiering
  - Migration impact

Paula directed Trustees to a chart in packet for enrollment numbers and mentioned that HDHP migration is generally slow when introduced as a new plan option. Mike Beaton reviewed the data from January enrollment. Numbers are not completely accurate, but close. Migration on HMO was negligible. Enrollment in HMO BluePriority (26) and Lumenos HSA plan (9) very low. Blaine pointed out that 35 employees is not many considering the amount of work involved in offering the two additional plans.

Michele confirmed that the target for migration was 10%, which was missed significantly. Anthem could request a load to premium because migration target was missed. Anthem agreed to waive the load.

- Actuarial Equivalency

  Actual equivalency doesn't consider the experience. Instead, looks at benefit design for two plans, using Denver as a neutral city, looking at Anthem Colorado costs, not CHEIBA costs. In past years, it has been very close. Reminder that it is based on Anthem's overall data, not CHEIBA's.

  Blaine commented that the PPO plan is being beat up because of selection, not actual equivalency.

  Anthem now sees the PPO and HMO designs to have a differential of 5.6%. The actuaries made a significant change in modeling tool, for first time in 5 – 7 years. PPO is valued to be more expensive at $759 compared to the HMO that is valued at $718.44. This creates the 5.6% differential. Michele addressed that in past there was not much of a difference between HMO and PPO. Now there is. Mike B. said much of it is due to the modeling tool.

  The CHEIBA Benefit Valuation handout outlines that the new modeling change creates a differential between the two plans. The HMO/POS seed value being $275 and the PPO seed value is $300. The differential has been slightly over 1% previously. As we approach pre-renewal, need to understand if we should increase total value of premium or increase PPO by some percentage. Part of reason we have blended rate was because we wanted employees to select plan based on individual family needs, not on premium.

  The PPO and HMO are grandfathered – can change rates up and down, but not benefits. Mike B. said would have implications for grandfathering. Michele said more factors will impact Grandfathered status. Mike D. said premium may be underfunded this year, and we might need to lose grandfather status. Mike B. pointed out that with 3.6% PPACA fee not being paid 2017, the coming year could buy back part of difference and help with losing grandfathered status.

Mike B. said rates for 2016 are still appropriate for 2016 risk. Smaller migration has virtually no impact.

Mike D. said we put the plans in place to respond to employee requests at some colleges. Why didn't people elect those plans? Marshall said premium differences were not enough to get excited about.

Michele / Mike B. – before renewal, should we look at differential on school contributions to make them more attractive? Mike B. will look into 1) plan value 2) risk. Plan value – can lower risk component in the rates. Add another 5 – 10 pts for getting better and better risk, but may need to load if no migration.

- Centura model billing practices update

  Janet Pogar, pulled a few months of claims data from the Urgent Care/ER facilities in Arvada and Golden. The results were very favorable. Out of the 118 visits, 7 were coded as ER and the rest were Urgent Care. Level 3, 4 & 5 care being received which is appropriate.

- Alternative Payment Models – member communication

  - Janet discussed a number of models. Shared flyer on Enhanced Personal Health Care and other individual models in January. Janet discussed with Mike D. and she believes the focus should be on the promotion of the tools and programs that specifically help the member, i.e., Dispatch Health, Cost and Quality Tools, 24/7 Nurseline, etc. Paula can provide assistance with communication of programs. Mike reinforced that he thinks simple education on the bells and whistles should happen on a consistent basis. Darren stated that consideration should be given on how it would differ with plan selections employees make, i.e., Live Health Online, Cost and Quality, Dispatch Health, etc. Mike encouraged all trustees to share with other Trustees any communication pieces that they use. Michele reminded that this will be discussed with universal communication strategy.

  - Castlight

    Paula reminded everyone that the Castlight cost and transparency tools are scheduled be released in 2017. An Anthem representative will demo Castlight capabilities in May.

- Live Health Online

  Through LiveHealth Online, Anthem members have access to a live video visit with a board certified doctor of their choice to discuss non-emergency health issues from home. The medical office visit charge for the HDHP is $49. For the other plans, members will pay their office visit cost share. Plan designs can be set up so that the member share is lower to promote steerage to LiveHealth Online. Behavior Health providers have recently been added to LiveHealth Online. The cost for a Live Health Online visit (45-50 min.) with a psychologist for the HDHP is $95. For a social worker, the visit is $80. For the other plans, members pay the mental health benefits cost share. This will result in less out of pocket costs for members. Mike reminded Trustees that it is important to get word out that this is an option to ER or UC. Providers can prescribe medications, with the exception of controlled substances, which require a face to face visit. Doctors do have access to plan information, but not access to medical records. For members who have registered to Anthem.com, Anthem will be pushing communication to members twice by email or phone promoting Live Health Online.

- Bundled Pricing Services – what can Anthem do for 2017

  Janet Pogar, talked with Centura, HCA, etc., and at this point there is not a solution for billing for bundling. The goal is to have the member receive one bill and one EOB for the anesthesiologist, hospital, doctor, physical therapy, etc. Anthem is currently piloting a program with PERA. There is not one provider in area that bundles surgeries under one bill. PERA is limited to an orthopedic bundle (multiple tax id numbers with a defined episode of care) at this time. Anthem does have a case rate agreement in place for all of their membership – not just limited to PERA - with Rocky Mountain Gastroenterology Associates for colonoscopies & endoscopies and Rocky Mountain Cancer Centers for radiation oncology. Until there is a way to process efficiently through system, let's not look at this as a solution. Michele said other organizations are offering bundled pricing for surgeries (i.e., Surgery Plus). Need to know around July if Anthem is making any progress here and if it is a possibility for January 1. There is specific interest in hips & knees. Don't want to trade convenience for claims accuracy.

  It was noted that there are no providers in the network for sleep disorders around Durango. Janet confirmed that Centura Sleep Center in Durango is contracted. Will follow up on specific providers in areas where gaps in specialists seem to be.

- All Clear - member communication update
  - Anthem provided an All Clear update provided with a Q&A document.
  - All members impacted by breach in Feb 2015 have coverage through All Clear through early 2017. Anthem is now offering to all new members as well since it is the right thing to do. It will be imbedded into plan with no action required. Flyer explains the protection details.
  - Postcards were mailed in early 2016, with quarterly mailings thereafter.
  - Working on long term mailing communication piece.
  - Kim noted that members not impacted by breach would not have coverage prior to early 2016. Anthem verified that is correct.
  - Members with coverage ready to expire in early 2017 will receive something soon on coverage being extended.
  - Communication timing issues: Paula could not get answers on behalf of individuals. Members with specific questions are required to call All Clear personally at 1-877-263-7995.
  - Ann suggested mentioning All Clear at new hire orientations. Paula to send something to share with new hires.
- Other Anthem Items
  - Fit Bit update - Desiree will be sharing winners of fit bits shortly.
  - Anthem PG Results – 2015 results reviewed by Paula at Anthem
    - Abandonment rate, average speed of answer, claims paid < 14 days easily exceeded the threshold defined in the performance guarantees.
    - Mentioned that $16K payout was given in early 2015 for ID card guarantee being missed.

- Processing Accuracy – Based on number of claims processed correctly. YTD results were at 97.23% vs target of 97%, so result within range.
- Financial Accuracy - Based on claim dollars paid correctly. YTD results were 97.53% vs target of 98% so this category was missed, resulting in a payout of $16,667.
  - Results were due to one claim in December with very high dollar overpayment error. The claim involved home infusion therapy. The claim was processed paying $84,249, with an overpayment of $75,474.60. The examiner paid for the incorrect units (18,000 vs 1,800). The overpayment was recouped in March 2015.
  - Mike D. asked how this could happen. Anthem explained that it was made by a new hires going through a training program. Mike expressed concern about other claims that could have been processed incorrectly and the financial impact. Janet explained that there are a number of claim audits in place to assure claims are processed accurately. Hospitals are quick to bring overpayments as well as underpayments to their attention in order to balance their books. Mike asked for further discussion on how the error rates impact the rates.

o Update on lawsuit - Jim at Anthem provided a copy of a press release provided to the press on the lawsuit against Express Scripts, Inc. (ESI).

Mike D. asked Jim to conceptually explain what it means to cost. Jim explained, ESI has relationships with manufacturers that may benefit ESI, that aren't necessarily a benefit to the clients and members. Anthem clinically manages their formulary. A clinic based committee and value assessment committee is in place and they review prescriptions from both a cost and clinical perspective. Clinic edits and guidelines are Anthems as well. Costs and rebate contracts are basically through ESI's contracts. From an enterprise perspective, Anthem does a market check to see where pricing falls. This time, it resulted in taking the next step with litigation. Anthem doesn't feel that the pricing received with ESI is competitive. Looking into self-funded market when looking at pricing request. Lawsuit is to assure they are in competitive position nationwide.

F. DISCUSSION AND INFORMATIONAL ITEMS:

9. Treasurer's Report –
   Operating account balance is approximately $40K. Transfer funds from another source, likely from Fidelity. Michele will advise. Auditors at Anderson and Whitney had confusion around CSU Global and CSU System but believe it has been worked out. Currently looking at GASB74 implications. Still trying to figure out the 60's. Blaine to have draft in the next week or so and will be approving at the May meeting.

10. Zero Card / Surgery Plus –
    Michele introduced the concept of new bundled pricing programs. Could be a great savings opportunity if decision is made to go self-funded at some point.

    Zero Card – Concierge service available for bundled services, e.g., hips, knees. Zero Card manages the outcome evaluation and credentialing. Member goes to concierge and they set up surgery through the facility. The facility finds a top doctor and everything is covered in a bundled price. Savings of 30 – 80% off per procedure. Mike pointed out LA Times article in

packet that addresses cost of these types of services. Concept is that employee pays nothing. Zero Card debits the employers account and costs do not go through the health plan. This works well for self-funded plans but not fully insured plans. Mike asked if there is a way to use surplus reserves to pay these funds. Zero Card started in Oklahoma, is currently in Texas, and in the process of opening in Chicago. They are currently wrapping up their network in Colorado/Denver Front Range, with a possible effective date of 1/1/17.

Surgery Plus – In place already in the Denver Metro area. The employer can set up plan design so the member does pay an out of pocket cost. Expenses process through as a medical claim. It's up to employer to set plan design then they share data with carriers. This may be an option for CHEIBA if/when the Trust moves to a self-funded arrangement. Both options have teams of excellent physicians. Both have consultative back surgeons. Can act as medical necessity review and second opinion. Upside is reduction in the price, and provides a service to employee of absolute known cost of episode of care. Janet confirmed they are challenged to make this work within Anthem right now.

11. Onsite Eye Exams –
    Paula explained that onsite vision clinics are available through Blue Vision. The onsite clinic is set up for 1 week with an eye doctor on site to provide exams. Lenses and frames are also available. Requirements for an onsite clinic include:

    - 450 or more employees at your location.
    - 2 separate lockable rooms (to protect PHI), with Wi-Fi, furniture, etc.
    - Buy in to promoting the vision clinic.

    Blue Vision has the capacity to offer to two locations for CHEIBA this year. Amanda and Blaine could coordinate one combined clinic since they are on the same campus. A concern was expressed that it would take business away from providers who wouldn't contract. Ann reinforced that clinics would hopefully catch employees that were not getting their eyes checked previously. This is just for convenience for the same $15 copay. A decision was made to move forward with two clinics. One will be with Amanda and Blaine combined, and the other will be with Ann. Anthem explained that they now has glasses.com and Contracts Direct through Blue View Vision. Flyer explaining programs provided by Anthem.

12. Contract Update –
    Dixon confirmed no contracting update needed. Status unchanged from discussion at January meeting.

13. Consideration of Data Release and Modification to Trust Agreement
    Mike referenced the Discussion Document in the meeting packet and introduced the topic with a brief overview of the history of data requests from specific institutions and their results. In 2002 and 2015, Metropolitan State University of Denver requested its data resulting in decisions not to leave the Trust. (There is a belief that MSU-D made a similar request in 2006 to Anthem, but Anthem has no record of providing data and the Trust has no record of the request.) In 2005, Mesa's request resulted in its decision to leave. Recently, CSU Global requested data with an unknown to the Trust intent. Usually a school decides to stay in the Trust, but it may choose to leave when its experience is favorable. It is not likely that a school would choose to leave when its experience is unfavorable.

Mike believes that guidelines should be in place with respect to member institution-specific data. He recently had a discussion with a Mines' business and economics professor who has participated in a number of boards. The faculty member stressed that as a fiduciary, a Trustee must represent the interests of the Trust and its participants rather than a particular institution. Mike further referenced the Discussion Document included in the packet that outlined the issues associated with data requests and fiduciary responsibility.

Mike noted that member schools and their employees benefit from the group size and strength of the Trust through lower overall administrative costs.

- Without the Trust, each entity would create its own benefits plan.
- Each entity would acquire its own benefits consultants and would see its costs substantially increase rather than share these costs. The average additional cost would be approximately $40,000 for each school.
- Each school would likely see some level of reduced marketing power and negotiation leveraging in obtaining services. Advantages with retention averaging and pooling points would also be lost.

Trust Article 5.3 provides for a common rate structure. This was agreed to by the member institutions at the establishment of the Trust and is in recognition of the concept of operating as a single entity with respect to risk, losses, and surpluses, rather than operating as an association of multiple entities. This concept was so fundamental to the Trust that Article 5.3 states that a three-fourths vote of the Trustees is required to change the common rate structure of Trust.

Blaine noted that the Trust Agreement requires a one year notice to leave the Trust; however, there is no penalty stated if a member institution does not provide the required notice.

Withdrawals can be a detriment to the Trust if the group that leaves has good claims experience. If they have worse experience, they will not leave. The risk to Trust is when those member institutions that happen to have considerably better experience than average leave.

Providing institution-specific data creates internal stress among the members and could have unintended consequences to the requesting member institution. It was noted that the Trust can be terminated by simple majority. One scenario that is possible would be in the event that a member institution's data were learned to be significantly worse than the remainder of the Trust. This could lead the Trustees to terminate the Trust as permitted in Article XII and reform another Trust excluding the schools with poor experience. The reason the Trust works is partly because of integrity of Trust members, as well as the data by member institution not being made available. Mike believes that reporting on Trust plan experience as a whole is fundamental to assure the continued strength of the Trust.

Marshall noted that he had engaged UNC's CFO in this discussion. The question is if they are putting institutions in bad spot by not allowing institution-specific reporting. The policy of restricting data reporting for the Trust as a whole is logical to maintain stability of the Trust while giving institutions what they need. They can get basic demographic data allowing them to get a market quote. Marshall believes operating as a single entity is one of the core principals of the Trust and has received support from leaders at his institution. Marshall is also respectful of others needs who may have new campus leaders.

Tracy commented, asking what is the responsibility of a Trustee. If an institution is being courted to go, it goes or not. If the data is available by institution, only the institutions with good data may go. Tracy believes that best interest of the Trust is to not release institution-specific data. Tracy's is concerned there is a lack of clearly spelled-out guidelines on data sharing.

Darren, agrees that as a Trustee, the fiduciary responsibility is to the Trust. Releasing the data doesn't benefit the Trust. Kim agrees from the discussion in January that it's not a good idea. She feels like this issue has been disruptive in the past.

Ralph's view is that institutions are created for the benefit of their employees. He believes that this language puts insecurities in minds of those who read the agreement in respect to the rights of the institution to do what it believes is in its best interest and in respect to transparency. Ralph doesn't feel that an institution leaving is practical concern as past movement has been minimal.

Amanda stated that she did not have a strong opinion either way.

Luc said data is what it is all about. The more data you can get into, the more you can use it to impact results. He sees many other benefits to the Trust, communications, etc. He feels transparency is important, specifically with Millennials. He can also see concerns with sharing the data.

Kim said the Trust looks at claims data as one big group. Everyone benefits from common rate with common claims data. If they look at claims data institutionally, it can lead to rating by institution. Kim believes this would not be in best interest of many institutions and doesn't want to look at the Trust differently for different reasons.

Blaine sees two sides. One – if we are going to allow individual campus data and when they pull their data, it should be open for everyone to view, and the Trust Committee can consider the claims data as well as the receiving institution. Two – the Trust member institutions can operate "intentionally being blind" to not looking at data by institution but using the data for Trust priorities that apply to all.

Mike said if a decision is made to be transparent with the institution-specific data, it should be shared with the Board every time it meets. However, he said from his past experience on another similarly structured benefits trust, providing institution-specific data resulted in pulling that trust apart. Mike believes that there are fundamentals to why the Trust was organized in the first place. Is the purpose still the same or has it changed?

Tracy noted the example of the triplets in 2015 and financial impact it would have had on a smaller school if the Trust had not been in existence sharing in the overall risk and claims experience.

Paula's opinion is that if you give anyone data, you should share data with everyone to be fair.

Further in the discussion, it was noted that if an institution requested its data, it has the opportunity to use that to its advantage if the experience was in its favor. Why not require that

the data would be available to the other entities in the Trust, and likewise, they could use it to their favor if indeed the experience was poorer than average. The other schools would have the opportunity to vote to end the Trust and reconstitute a new Trust without the poorly performing institution.

Michele shared results of a contract comparison completed after interviewing several Gallagher representatives who work with other trust and co-op entities. Six Technical College Consortiums were reviewed, with the majority from the state of Illinois. Illinois state law requires the sharing of data; however, most of the groups confirmed they do not ask for it. Contractual provisions don't address marketing in most cases. Blaine asked if they were self-funded, would it be open record since they owned the data. Discussion resulted in likely not. Gallagher would need to review to be sure.

Tracy moved to add the Proposed Trust Language 6.2(e) as follows from the discussion document. Darren seconded the motion.

Consistent with the concept of an annual common contribution rate and a common contribution rate structure as described in Articles 5.2 and 5.3 of this Trust, all claims data, claims reports, and claims analyses will be made only on the basis of the Trust as a whole. No individual College-specific claims data, claims reports, or claims analyses shall be provided to any College or to any individual or entity. This Section 6.2 (e) may be changed only by a three-fourths (3/4) vote of the entire Trust Committee.

Blaine offered a friendly amendment to change language to:

Consistent with the concepts of an annual common contribution rate and a common contribution rate structure as described in Articles 5.2 and 5.3 of this Trust, all claims data, claims reports, and claims analyses will be made only on the basis of the Trust as a whole. No individual College-specific claims data, claims reports, or claims analyses shall be provided or authorized to be provided to any College or to any individual or entity. This Section 6.2 (e) may be changed only by a three-fourths (3/4) vote of the entire Trust Committee.

Tracy accepted the friendly amendment language. Darren asked if would be necessary to add this language in other areas of the Trust agreement. This would apply to all lines of coverage at this time. Policy is on an aggregate basis, so audits, etc., would be on an aggregate basis with the exception of the FSA which is a Section 125 IRS governed document with no claims data to report.

Due to the sensitivity and potential impact of the motion, Mike asked for a vote by member institution resulting in the following:

Marshall Parks, University of Northern Colorado - yes
Kim Gailey, Western State Colorado University - yes
Darren Mathews, Fort Lewis College - yes
Blaine Nickeson, Auraria Higher Education - yes
Mike Dougherty, Colorado School of Mines - yes
Tracy Rogers, Adams State University - yes
Ralph Jacobs, CSU Pueblo - no
Amanda Berry, Metropolitan State University of Denver - yes

Dixon will draft the necessary amendment incorporating the approved Article 6.2 language.

14. DispatchHealth – Jeff Messer, VP Marketing and Development, Mark Prather – CEO
DispatchHealth provides on-demand healthcare in the convenience of your own home. It helps members avoid unnecessary expenses and trips to the ER. DispatchHealth can treat: pains, sprains, cuts, wounds, high fevers, upper respiratory infections and much more. Prepared to perform labs, administer IV fluids, nebulizer treatments, split and stitch wounds, order prescriptions. They dispatch board certified clinicians to your home, equipped with all the tools necessary to provide advanced medical care. They will triage care, treat if needed and arrange transport to hospital only if needed. The medical team is comprised of an ER trained Nurse Practitioner and EMT, supported by an ER doctor at all times for phone and video consultations. Hours of operation are now 9:00 a.m. – 9:00 p.m. Expanding to 8:00 a.m. – 10:00 p.m. soon, with goal of being 7:00 a.m. – 11:00 p.m. Half of the staff can speak Spanish. Patients report a 94% patient satisfaction rate. Only 2% of the patients are readmitted to ER, instead of typical 25%. Ambulance fee significantly less.

    Available currently from Castle Rock, to Westminster/Arvada to Aurora and Foothills. Expanding soon to Boulder, then Ft. Collins and Colorado Springs. Currently contracted with Anthem as in-network provider, as well as other major health insurance companies.

    Dispatch Health Mobile App functionality was shared and appears to be very user friendly. When initiating a call, it goes directly to a provider who will triage the situation and answer questions. The patient has the ability to send a picture or video, often avoiding the need for a visit at all. In this case, there is no charge. When a medical team is dispatched, the patient will receive a picture on the phone so they know who will be arriving at their home.

    Provides significant cost savings to plan and member. There are no facility fees. Visits are billed as a bundled in-network contract rate of $250. Currently working on adding home radiology services. They also have a $150 bundled rate for ultrasonic services. DispatchHealth partners with several fire departments. For less critical calls, DispatchHealth will meet them at the scene, treat and release patients avoiding the need to transports to the ER. For this, there is an additional $200 charge to the $250 visit charge. They are also working with Pinnacol on Workers Comp claims. Each vehicle can handle 3,200 visits per year. There are 2 vehicles in service now with 2 more being released within next few months. Currently DispatchHealth queries the Health Information Exchange (HIE) when they arrive on site. HIE is a system that enables the exchange of electronic medical records between hospitals and providers. Dispatch Health is working on connectivity to query the HIE for decision support, but this is not yet operational. Strong Primary Care model, reporting back to PCP after visits. Can video conference when appropriate. Being on-site allows for identifying other risks within the home, i.e. animals, view of medicine cabinet, unsafe environment, etc.

    DispatchHealth offers three Plan Options:
    - Standard - Free
        - Access to communication materials to promote engagement
        - On demand acute care coordination
    - Engagement Package
        - Standard Package

- PEPM $1.50 to build engagement campaign
  - Engagement services, wellness fairs, plan design support, reporting
- Premium Service Package
  - Engagement Package PLUS
  - Per session $20
  - Virtual Triage – secure texting

There was discussion about how this competes with Telemedicine. It is a good concept, but patients are not comfortable using video, may be creating visits that aren't necessary.

DispatchHealth is considered a contracted provider with Anthem. After the claim is processed, the member will be responsible for the amount they would have paid for a specialist visit. This would be a $20 under the POS plan, and 15% after the deductible for the PPO plan.

Slide deck and communication materials will be shared by Michele.

15. Data Mining/Engagement -
Michele explained there are infinite number of ways to slice and dice data. Gallagher has provided information on demographics, etc. The base data is always Anthem's. Michele suggests using Anthem's data to the maximum capacity. Health Analytics was considered providing the same data, but a different view. A rhetorical question was stated: "Why pay another vendor for same data?" It makes more sense to work with Anthem to customize reports. Grand Round has unique capabilities. With their model, they take data and create a dashboard. They work with 15K physicians. They engage with these physicians using data to engage with patients. Anthem does reach out to members in disease states, but we know employees are not likely to engage. Engagement is much better at physician level. Grand Round is available in the marketplace. Mike suggested including Grand Round in the education session in July. Michele suggests going back to Anthem and coordinate with Gallagher's predictive modeling tools.

16. Optimize CBGH membership
Michele reviewed a document with action steps proposed by CBGH to optimize the programs available to CHEIBA.

- Bridges to Excellence (BTE) Recognized PCPs
  - Studies show BTE physicians achieve better outcomes, resulting in an opportunity to save $500 - $800 per diabetic per year
  - CBGH would take Anthem data and identify physicians and initiate recruitment. Anthem's data would be de-identified since we are fully-insured.
  - Focus on Diabetes for 2016, with Cardiac introduced next. Provider would be paid $100 per patient. No charge for 2016, but would begin charging back to CHEIBA for 2017.

Mike D. asked if this would be duplicating programs already in place with Anthem. Paula confirmed that the Diabetic Prevention Program (DPP) through Anthem is specifically for pre-diabetics. The Bridges to Excellence is a program which rewards physicians whose clinical outcomes for the diabetic patients they see meet or exceed national standards.

- Leapfrog Hospital Safety Profiling
  - Leapfrog is for evaluating hospitals, CHEIBA specific and geographic specific. Even if they receive the data, to Mike's point, it would make sense to compare Anthem's data and discuss the appropriate approach before talking with hospitals. Kim pointed out that if a hospital fails to participate in Leapfrog, the data won't be available.
- Prometheus Analytics
  - Provides an opportunity to analyze potentially avoidable complications/costs for 6 chronic diseases.
  - There is a cost of $1.80 PEPM or .82 PMPM not mentioned before, close to an additional $70K. CBGH will provide for no charge for one quarter, with no commitment to continue. If the Trust sees the value, they can discuss adding to the budget.
- eValue8
  - Health plans can be benchmarked against national standards regarding quality health care services and contracting practices. Anthem confirmed that they have chosen not to participate. Mike D. would like Paula to get a clearer picture of why they will not participate. Paula said they feel they do not represent Anthem fairly.

The Trustees would like to pursue Bridges to Excellence, Leapfrog and Prometheus (for the 3 months at no charge) through CBGH at this time. Mike needs to sign release from Anthem. Paula and Mike to finalize on Monday.

17. July Annual Meeting – education session topics

    Meeting to be held Monday – Wednesday, July 25- 27, in Breckenridge, with the educational session on Wednesday July 27 starting at 10:00 a.m. This will allow alternates time to arrive that morning. Blaine may not be able to attend.
    - July annual meeting topics:
      - Fiduciary training – conducted by an attorney
      - Grand Round
    - Discussion around topics for May meeting which is moved to June 2-3
      - Castlight demo

18. ColoradoCare (Amendment 69)

    Tracy and Michele attended a recent meeting discussing Amendment 69, ColoradoCare. Amendment 69 is a state constitutional amendment for November's ballot to create "ColoradoCare", a single-payer, government run health care system in Colorado. ColoradoCare would replace all of the existing health-insurance plans being sold in the state and replace them with the plan offered by a state-chartered organization that would be funded with a 10% payroll deduction per employee. The public exchange as we know it today, as well as other state-run programs (children's health programs, etc.) would be eliminated. Unsure if would affect federally funded programs (i.e., Medicare/Medicaid). Would ask for opt out of the federal programs.

    Mike asked if it would affect PERA care. Michele believes it may but it's not clear. There are theories in place but no sample contracts at this point. The supporters are claiming that all providers would participate, saying they will use the Medicare reimbursement schedule. If it's not required though, it's hard to say how they can state all providers will participate.

    Elected officials would oversee and govern ColoradoCare. They would break down into seven congressional districts. A question was asked, if Amendment 69 were to pass, would it mean

that the insurance carriers are out of business. Michele said yes, unless they are chosen as carrier for the program. Excludes Tricare and other plans covered outside of state.

The cost to support ColoradoCare is estimated at $25 Billion. Ralph asked if the 10% was higher or lower than premium paid now. Confirmed lower, but Tracy confirmed this is very much a rough number. Mike explained that Medicare's estimated cost when it was introduced was significantly underestimated ($12 Billion vs. $98 Billion). Michele said it's impossible to have any idea of who will participate and the actual costs before the reimbursement rates are set in the plan.

From the CBGH meeting, the overwhelming response from employers was not favorable, with many questions. Ann noted that the benefit design would be free care for all. Discussion ensued on the potential for people moving to Colorado for free care, as well as people moving out of state because they did not like a government run system. Discussion also contained conjecture about how it would affect keeping quality providers in the state. Michele mentioned that the new Primary Care Models introduced now seem to be working. Experience with Accountable Care Organizations is still too early to tell. See attachments in packet: Proposed Initiative #20 and Summary of Colorado Care – Amendment 69. For now, keep on watch list item. Add to May agenda to address updates if any.

19. Premium Holiday Discussion – 8:30 a.m. Friday

A discussion was added to the agenda regarding the funding source for the Premium Holiday for 2016, led by Mike Beaton from Anthem. The decision in November 2015 to provide a 2016 Medical half-month Premium Holiday would result in appx $2,371,938 less premium. The Medical RSR contract requires the most recent Medical Surplus estimate to equal or exceed the requested premium holiday. The 2015 end of year estimate provided by Anthem actuarial in July was approximately $1.1 million, which would be inadequate to cover the full half-month Premium Holiday. It was suggested that the CHEIBA Life RSR has sufficient funds and could be a source to move funds from to create an adequate Medical Surplus reserve amount for the 2016 premium holiday action.

Mike B. apologized for not being at the November meeting so the issue/topic was not addressed at that time. If he were there, he would have realized that the medical/dental surplus did not meet or exceed the premium holiday amount. Anthem will need to transfer life surplus over to the medical reserve to cover the premium holiday.

Mike D. asked with respect to life insurance plan, "What is the experience period based on, calendar or physical year?" Mike B. does not know but will find out and respond back to the Trustees. For the life contract, Exhibit B of the original contract from 2004 Claim stabilization reserve, part C, paragraph 4 (Mike D. read the paragraph) noting that if the experience period is annual, the Trust is still within still the 120 days' notice period. Mike B. will need to review what experience period applies.

Michele said during the November meeting the Trust reviewed the reserve allocation report which showed enough unencumbered surplus dollars to cover the premium holiday and that is what the decision was based on. No discussion was brought up by Anthem at the time about a required notification to transfer life surplus into the medical account. When having discussions

to decide if a premium holiday is feasible, the Trustees make a decision based on all product lines. Mike B. said those external documents do not drive the contract.

Mike B. said he will have to dive in to the contract further, but he just wanted to make sure everyone was aware that the premium holiday exceeded the $938K surplus. He wants to be diligent as to what the contract states, iron it out and do what is required. Mike B. took complete responsibility. Mike D. confirmed that the most current life contract document is from 1988, with a stamp reflecting an amendment in 1995. Mike D. sent the contract document via email to Mike B. and Michele.

Dental 2015 RSR year-end estimate has $600K in the Surplus account. The Dental half-month premium holiday is valued at around $100K, and therefore the Surplus account is adequate for a 2016 dental premium holiday.

Mike D. believes the experience period is January, and contract says 120 days, so it appears to him that the Trust is within that timeframe for notice. The Trust would like to consider amending the contract to state when the actual accounting period takes place.

Mike B agrees with Mike D that the late 2015 decision making for Medical and dental renewal actions is odd because the 2015 RSR year-end estimates are not final until much later in 2016. However, both client and carrier only have the estimated 2015 calculations to use due to the timing of the renewal cycle. It is possible that the estimated calculation of surplus could be significantly off should utilization change dramatically in the interim months before the final is calculated. Decisions for 2016 renewal funding must be made prior to the availability of final calculations but this unique funding vehicle approves of decisions being made with estimated calculations only.

20. May Meeting Discussion
    With the next meeting scheduled the last week in May, there was a concern raised with timing of the reporting due to the Memorial Day holiday. GBS cannot guarantee that the data will be ready in time. Mike and Blaine discussed scheduling next year's meetings with timing of reports in mind, likely move to the first week of the month.

    A motion made to move the meeting to June 2nd and 3rd. Tracy seconded the motion. Luc has a conflict but can attend as scheduled in May. A consensus was reached to move to June 2nd – 3rd. Meeting will be held in Alamosa. Mike D. confirmed that no motion was made when the Trust originally scheduled the meeting dates, so no motion was needed to change. Anthem to confirm as soon as possible that their team can accommodate the date change.

EXECUTIVE SESSION - The Trust may convene in executive session pursuant to §24-6-402(3)(a)(II), C.R.S., to confer with the Trust's attorneys for the purpose of receiving legal advice.

No Executive Session was held

G. ADJOURNMENT

A motion was made to adjourn the meeting. The motion was seconded and approved.